# CHAPTER V

# PREAUTHORIZATION

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## GENERAL INFORMATION

Prior authorization by the Medicaid Central Office is required for payment to be made for covered prostheses (artificial arms, legs, their necessary supportive devices, breast prostheses, and penile implants).

The preauthorization request must include the Prosthetic Device Preauthorization Request form (DMAS-4000), the physician's order/prescription, the provider's plan for training the patient in the use of the device, and the Physician Certification of Need form (DMAS-4001) completed by the prescribing physician.

To obtain the required preauthorization for artificial arms, legs, their necessary supportive devices, and breast prostheses, the prosthetic device provider must complete and submit the required Prosthetic Device Preauthorization Request, attach a copy of the physician's prescription and the completed Physician Certification of Need Form, and mail them to:

Director, Medical Support
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

## PREAUTHORIZATION FORMS

The Prosthetic Device Preauthorization Request Form and the Physician Certification of Need Form can be downloaded from the DMAS website (www.dmas.virginia.gov) See Chapter VI of this manual for additional instructions for obtaining forms.

## PREAUTHORIZATION INQUIRIES

Since implementation of the Virginia Medicaid Management Information System (VAMMIS), prior authorization letters are system generated. All decisions are updated in VAMMIS and assigned a preauthorization number. The decision information is available to providers through the Automated Response System (ARS)

Authorization status is available 24 hours per day, 7 days per week through the ARS. Providers can complete registration for the ARS online at http://virginia.fhsc.com, or can contact the Provider Helpline at:

1-800-552-8627 (in-state long distance toll-free); or
(804) 786-6273 (out-of-state, Richmond area and long distance).

**PREAUTHORIZED SERVICES FOR RETROACTIVE ELIGIBILITY**

For services requiring preauthorization, all preauthorization criteria must be met in order for the claim to be paid. For those services occurring in a retroactive eligibility period, authorizations will be performed by DMAS retrospectively.

## INSTRUCTIONS FOR THE COMPLETION OF THE PREAUTHORIZATION REQUEST FORM

The required Prosthetic Device Preauthorization Request (DMAS-4000) must be completed and submitted to DMAS for reimbursement approval for prosthetic devices which have been prescribed by a practitioner within the scope of his or her license. A copy of the prescription, as well as a copy of the Certification of Need Form (DMAS 4001), must be attached to the request.

**Item 1.** Enter the date the form is prepared.

**Item 2.** Enter the name of the patient.

**Item 3.** Enter the patient's 12-digit Medicaid number.

**Item 4.** Enter the patient's Medicare number.

**Item 5.** Enter name of the prescribing physician.

**Item 6.** Use as many lines as necessary to describe the prosthetic device and required supportive items.

**Item 7.** Enter the diagnosis of the patient's condition if available.

**Item 8.** Describe the patient's functional limitations.

**Item 9.** Enter comments regarding the acceptance of the device by the patient.

**Item 10.** Enter the psychological and/or therapeutic value expected for the patient.

**Item 11.** Enter any employment possibility.

**Item 13.** Enter the name of the participating prosthetic device provider submitting the request.

**Item 14.** Enter the Medicaid provider number assigned to the participating prosthetic provider.

**Item 15.** Enter the provider's or his or her agent's signature.

**Item 16.** Enter the date signed.

**Item 17.** Enter the telephone number for inquiries.

**Item 18.** To be completed by the Medicaid Central Office.

**INSTRUCTIONS FOR THE COMPLETION OF THE CERTIFICATION OF NEED FORM**

**Item 1.** Enter the name of the patient.

**Item 2.** Enter the patient's 12-digit Medicaid number.

**Item 3.** Enter the date of the most recent amputation for the limb to be replaced by the prosthesis.

**Item 4.** Enter the patient's date of birth.

**Item 5.** Enter the patient's current weight.

**Item 6.** Enter the patient's current height.

**Item 7.** Enter the diagnosis for which the patient had the amputation (if applicable).

**Item 8.** Enter the reason for the patient's amputation (if not described in Item 7).

**Items 9-13.** To be completed by the prescribing physician.

**Item 14.** To be completed by the prescribing physician. Please note that all special components of the prosthesis must be medically justified components, not convenience items.

**Items 15-17.** To be completed by the prescribing physician.

**Item 18.** Enter the physician's name.

**Item 19.** Enter the physician's signature.

**Item 20.** Enter the physician's address.

**Item 21.** Enter the physician's telephone number.

If additional space is needed for explanations of certain items, include a letter addressing these items.

# EXHIBITS

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# PREAUTHORIZATION REQUEST FORM (DMAS-4000)

VIRGINIA MEDICAL ASSISTANCE PROGRAM
PROSTHETIC DEVICE PREAUTHORIZATION REQUEST FORM

1. DATE _____
2. PATIENT'S NAME _____
3. PATIENT'S MEDICAID NUMBER _____
4. PATIENT'S MEDICARE NUMBER _____
5. NAME OF PRESCRIBING PHYSICIAN _____
6. DOCTOR _____ PRESCRIPTION INCLUDES THESE ITEMS:

| | HCPCS CODE(S) | DESCRIPTION |
|---|---|---|
| a. | | |
| b. | | |
| c. | | |
| d. | | |
| e. | | |
| f. | | |
| g. | | |
| h. | | |

7. DIAGNOSIS _____
8. FUNCTIONAL LIMITATIONS _____
9. DEVICE ACCEPTANCE _____
10. PSYCHOLOGICAL/THERAPEUTIC VALUE _____
11. EMPLOYMENT POSSIBILITY _____
12. PROSTHETIC DEVICE HISTORY _____

**PROVIDERS STATEMENT**

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this request will be from federal and state funds, and that any false statements or documents or concealment of a material fact, may be prosecuted under applicable federal and state laws.

13. SUBMITTED BY _____
14. PROVIDER NUMBER _____
    PROVIDER ADDRESS _____
    _____
    _____
15. SIGNATURE OF PROVIDER/AGENT _____
16. DATE _____ 17. TELEPHONE (_) _____

**FOR OFFICE USE ONLY**

APPROVED _____
DENIED _____
PENDING _____
COMMENTS:

REVIEWER SIGNATURE _____ DATE _____

DMAS-4000

# CERTIFICATION OF NEED FORM (DMAS-4001)

**PHYSICIAN CERTIFICATION OF NEED**

Dear Doctor:

To expedite the processing of request for funding of prosthetic devices for your patient, the Department of Medical Assistance Services seeks your assistance in contributing medical information so that an appropriate decision can be made promptly. Please complete the following where applicable and forward to the prosthetist for their submission with the preauthorization request form or send to Medical Support Section, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

1. _____ Patient's Name
2. _____ Medicaid Recipient I.D. Number
3. _____ Date of Amputation
4. _____ Date of Birth
5. _____ Weight
6. _____ Height
7. _____ Diagnosis
8. _____ Reason for Amputation
9. Are other amputations anticipated within the next twelve months?
10. If this patient has undergone a lower extremity amputation, please include the date the patient last ambulated:
11. Please list any current significant medical conditions and their present treatments, e.g. arthritis, vascular disease, neuropathy, diabetes:
12. Is the patient cognitive and physical status sufficient to enable learning the use of a prosthesis?
13. If the patient has had a prosthetic limb, why does it need to be replaced or repaired?
14. Additional medical justification for special prosthetic components, e.g. lightweight equipment, special terminal devices, modified sockets, modified feet, etc.:

**PHYSICAL EXAMINATION**

15. Please indicate strength testing of all extremities, including range of motion across all joints. This should include the contralateral limb:
16. Are there any signs on examination consistent with vascular disease in the contralateral limb? Give it's present condition and viability.
17. Are there any conditions that would preclude or delay the use of prosthesis, i.e., edema, open wound, contractures or poor skin viability?
18. _____ Physician's Name
19. _____ Physician's Signature _____ Date
20. _____ Street Address
21. _____ Physician's Phone Number

_____ City, State, Zip Code

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